DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's webinar is:

Evidence-based Treatment and Prevention for Suicide and Related Outcomes

Sept. 18, 2013, 1-2:30 p.m. (EDT)

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Deputy Director, National Center for Telehealth and Technology

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

Webinar Details

- Live closed captioning is available through federal relay conference captioning (see the “Closed Captioning” pod)
- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
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  - Use participant pass code: **3938468#**
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- The authority for training of contractors is at the discretion of the chief contracting official. Currently, only those contractors with scope of work or with commensurate contract language are permitted in this training.

Continuing Education Details (continued)

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  - 1.75 CE Contact Hours Physical Therapy and Occupational Therapy
  - 1.5 Nursing Contact Hours
  - 1.5 Social Work CE Hours
  - 1.5 APA Credits for Psychologists
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Continuing Education Details (continued)

If you pre-registered for this webinar and want to obtain a CE certificate, you must complete the online CE evaluation.

- The Swank HealthCare website will open immediately following the webinar and remain open through **Wednesday, Sept. 25, 2013,** at 11:59 p.m. (EDT).
- If you did not pre-register, you will not be able to receive CE credit for this event.

Evidence-based Treatment and Prevention for Suicide and Related Outcomes

An abundance of research evidence exists to support early suicide prevention and treatment. Existing studies identify the risk characteristics of the military population as a topic of considerable scientific and public interest.

During this webinar, participants will gain knowledge about current research evidence related to early prevention and treatment, learn differences in treatment for high-risk populations and recognize the challenges of evidence-based treatment and prevention strategies for suicide and related outcomes.

This webinar will:

- Demonstrate knowledge of the overall evidence available for treatment and early prevention of suicide and related outcomes (i.e., depression, interpersonal violence, increase in access to mental health services)
- Describe the differences between treatment for high-risk populations (e.g., veterans with multiple comorbidities, older adults, men) and prevention strategies for communities
- Recognize and describe methodological challenges in the study of evidence-based treatment and prevention for suicide and related outcomes

Presenter

Dr. Kerry Knox

- Graduated Northwestern University with a master's in Anthropology and a Ph.D. in Biological Science
- Serves as an Associate Professor in the Department of Psychiatry at the University of Rochester Medical Center in NY
- Founding Director of the U.S. Department of Veterans of Affairs Center of Excellence for Suicide Prevention in Canandaigua, NY, and served in that capacity from 2006-2012.
- Work with suicide research and prevention began in 2002 with a National Institute of Mental Health (NIMH) grant dealing with suicide prevention in the U.S. Air Force (USAF) and continued in 2006 with another NIMH grant also dealing with suicide prevention in the USAF; recently awarded a third NIMH grant that continues this line of research
- Developed novel methodological approaches to study the effectiveness of a sustained, multi-faceted suicide prevention program in the USAF as well as measures of implementation of this population-based prevention program

Evidence-based Approaches Depression and Suicide

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Disclaimer

The views expressed in this presentation are those of the presenter and do not reflect the official policy of the Defense Department or U.S. Government. This presenter has no financial interests to disclose.

Key Acknowledgements

- Department of Veterans Affairs (VA): multiple collaborators for past 7 years (in particular VA Office of Mental Health and Dr. Jan Kemp, National Mental Health Program Director for Suicide Prevention and Community Engagement)
- United States Air Force: multiple collaborators for over 13 years
- University of Rochester Medical Center, Department of Psychiatry and Center for the Study and Prevention of Suicide: multiple collaborators for over 13 years
- Collaborators at other many other Universities

Goals Today

- Discuss evidence for effective clinical and population based approaches to treatment/prevention of suicide and depression
- Discuss strengths and limitations of the current evidence
- With examples of ongoing studies/projects – both clinical and population based approaches

Suicide Statistics

- 38,364 people in the United States died by suicide in 2010
- Third leading cause of death in young people
- Recent statistics show an increase in the population in the middle years of life
- These figures are probably an underestimate
- Often difficult to determine if a death is a suicide (e.g. automobile accidents, drug over doses)

Public Health Approach

- Includes the health of the individual in addition to the health of the population
- The health of individuals and groups depend upon social policies & programs (e.g., access to care), and national, regional, and community efforts that are, at once, coordinated and diffuse
- Public health promotes the building of healthy communities, **including emphasis on connectedness**
- Public health now far exceeds the scope of traditional public health; suicide and depression both viewed as a public health problem

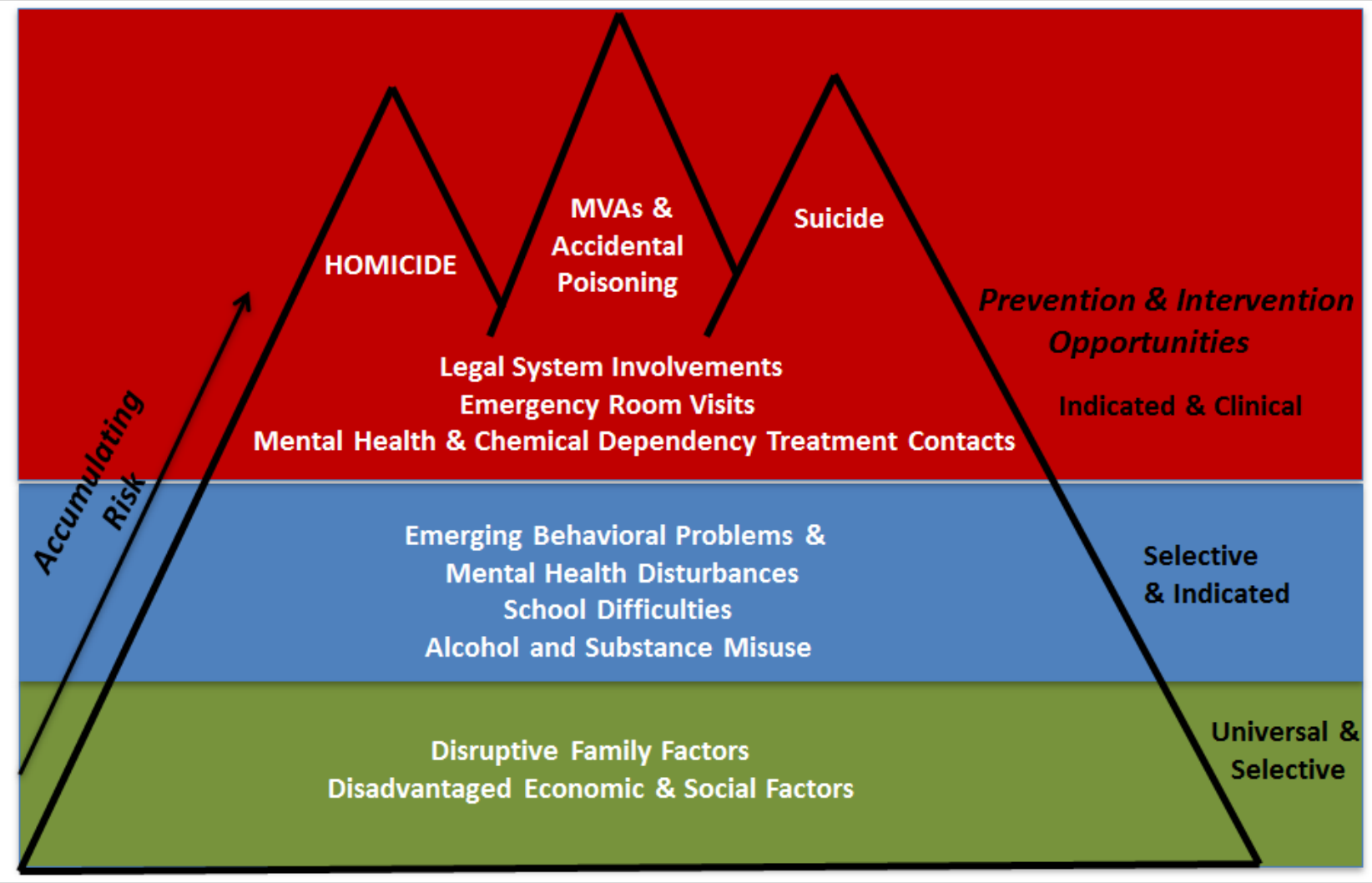
Challenges to the Field

- Translation of research in actionable items via public health policies
- Importance of integrating individual and population approaches
- Challenges of integrating individual and population approaches for a true public health approach

Challenges to the Field

- Setting an agenda for the way forward (Caine ED; AJPH; 2013; Caine, Knox, Conwell; Population Mental Health; 2011)

Premature Death in Early Adulthood
Common Developmental Contexts for Different Adverse Outcomes



Background

- Evidence for Clinical Approaches for Treating Depression and Reducing Deaths from Suicide
- Crisis lines as first line offense
- Lithium and Selective serotonin reuptake inhibitors (SSRIs) – the debate
- Cognitive Behavior Therapy (CBT)
- Dialectical Behavior Therapy (DBT) depression and suicide
- Brief Interventions
- Follow-up approaches
- Combination – Example: Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET)

Evidence for Clinical Approaches

Crisis Lines

- Work of Gould and colleagues in community crisis lines (Gould et al SLTB; 2012; http://www.suicidepreventionlifeline.org/
- Found that distress is reduced in callers, including depressive symptoms, from beginning to end of the call
- Callers are essentially anonymous; difficult to study long term outcomes

Evidence for Clinical Approaches

Crisis Lines

- Mishara et al (SLTB 2007) investigated effectiveness of community crisis lines; in particular compared models of helper behavior to actual practice in telephone crisis intervention

Evidence for Clinical Approaches

Lithium and SSRIs

- Effectiveness of lithium in depression well documented
- Effectiveness of lithium in reducing suicidal behaviors has mixed results
- Large trials difficult to attain sufficient numbers of subjects due to issues with compliance

Evidence for Clinical Approaches

CBT and DBT

- Effectiveness of Cognitive Behavioral Therapy (CBT) as been demonstrated in several large trials (Brown et al, JAMA 2005)

- Effectiveness of Dialectical Behavior Therapy (DBT) shown to be effective, especially in females diagnosed with borderline disorder (Linehan MM, et al., Arch Gen Psychiatry 2006)

Challenges to Evaluating Effectiveness

- Time consuming to train and supervise clinicians
- Costs of randomized control trials
- Statistical power
- Potential sample bias

Rationale…

- Ongoing outpatient treatment is not for everyone--- “Been there, done that.” “Stigma.” “Not my cup of tea.” “Inaccessible.”

- Of those who do attend treatment, 3 months after hospitalization for an attempt, 38% have stopped outpatient treatment (Monti et al., 2003)

- After a year, 73% of attempters will no longer be in any treatment (Krulee & Hales 1988)

Evidence for Clinical Approaches

Brief Behavior Interventions

- Individuals are at elevated risk for further suicidal behavior for 3-6 months after a suicidal crisis (e.g. suicide attempt)

- At risk patients are difficult to engage in outpatient psychotherapy (Lizardi & Stanley, 2010; Trusz, et al., 2011); 11-50% of attempters refuse or drop out of outpatient therapy quickly (Kurz & Moller, 1984)

- Some individuals (adolescents and young adults) tend to have attitudes that are inconsistent with long term therapy

Brief Behavior Interventions

Evidence for Clinical Approaches: Brief Behavior Interventions

- “The past is the past, it won’t reoccur”
- When mood improves, it’s hard for them to imagine that it could worsen again
- Up to 60% of suicide attempters < 1 week of treatment post ED discharge (Granboulan, et al., 2001; King et al., 1997; Piacentini et al., 1995; Trautman et al., 1993; Taylor & Stansfield, 1984)

Example of Studies

VA: Study of all Veteran callers, regardless of risk level for suicide, to VA's 24/7 Crisis Line Crisis Line: 1-800-273-8255 http://veteranscrisisline.net; developed by Dr. Jan Kemp, VA Office of Mental Health, National Director of Mental Health Programs for Suicide Prevention and Community Engagement

VA: Studies of a brief intervention to reduce suicide and suicidal behaviors in Veterans at moderate risk for suicide identified in VA Emergency Departments (Knox et al, AJPH; 2012)

VA 24/7 Crisis Line

(Developed by Dr. Jan Kemp, VA Office of Mental Health)

- Unlike other crisis lines, VA's crisis line provides follow-up services to consenting Veterans

- VA is uniquely positioned to address three key questions to address a critical question of whether crisis lines are effective

Knox KL, Kemp J, McKeon R, Katz I. Implementation and early utilization of a suicide hotline for Veterans. American Journal of Public Health; 2012; 102:S29-S32

Knox KL (PI); Gould M, Cross W, Tu X (Co-PIs): NIMH R34

- The rationale for conducting this study is to provide pilot data that would contribute to the development of a larger study on the compliance, fidelity and variation in delivery of mental health crisis services within a large healthcare organization

- Such a study requires a better understanding of mutable factors that impact access, utilization, quality and outcomes associated with the mental health services provided through VA's Crisis Line

- Similar to other suicide crisis lines, VA's crisis line affords rapid access especially during periods of high distress

Funding

- Outcomes in Callers to the VA's 24/7 Veterans Crisis Line

- NIMH 1R34MH096854-01A1

Significant Questions

- The potential for differences exists and may be due to a number of factors, including the nature of the conflicts each of these cohorts were involved in, which resulted in unique exposures for different groups of Veterans

- Are there differences between populations of returning Veterans, Vietnam Veterans, and aging Veterans from other wars who call the crisis line?

- In addition, there may be a significant impact of responder behavioral characteristics that have an impact on whether a Veteran engages in further care

Aims

1. *Of the entire population of potential callers to a crisis line, what are the characteristics of individuals who call a crisis line? (Aim 1)*
2. *What are the key behavioral characteristics of responders that moderate individual characteristics of callers, resulting in acceptance of a referral given from a responder to the caller? (Aim 2)*
3. *Is there an impact on important outcomes: death from suicide, suicide attempts and reattempts, hospitalization for suicidal behaviors, engagement in an ongoing safety planning process, and overall reductions in psycho-social distress? (Aim 3)*

What is SAFE VET

- Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment Project (SAFE VET)
- VA effort at targeting moderate suicide risk Veterans who are discharged from the Emergency Department (ED)
- Two components:
  1. ED-based clinical intervention (Safety Planning)
  2. Structured telephone follow-up

What is SAFE VET

- Funded for three years by VA Office of Mental Health, as recommended by a Blue Ribbon Panel in 2007
- Initial implementation and results published:
- Knox KL, Stanley B, Currier G, Brenner L, Holloway M, Brown G. An emergency department based brief intervention for Veterans at risk for suicide (SAFE VET). American Journal of Public Health; 2012; 102:S33-S37.

Target Population and the Need

- Veterans who are assessed as moderate suicide risk who are discharged from the ED
- Providers often hospitalize moderate risk Veterans
- Limited alternatives midway between hospitalization and outpatient care
- Limited interventions available in the ED
- Following discharge from the ED, it takes time to get into outpatient care – follow-up provides a safety net during this high risk period

SAFE-VET Hypotheses

SAFE-VET intervention includes: 1) structured risk assessment; 2) safety planning, and 3) structured follow-up (problem solving & motivational enhancement).

At 6 months follow-up, Veterans who receive the Safety Planning + Follow-up Intervention as compared to controls will demonstrate:

1) Significantly lower level of suicide ideation
2) Significantly reduced rate of suicide attempts
3) Significantly greater number of suicide-related coping strategies
4) Significantly higher likelihood of attending mental health and substance abuse treatment

SAFE-VET Study Criteria

Inclusion:

- ❑ Veterans Receiving SAFE-VET Safety Planning Intervention OR Usual Care at VA EDs or Urgent Care Settings
- ❑ Determined To Be At Risk for Suicide by ED
- ❑ 18 Years of Age or Older
- ❑ Able to Provide 2 Verifiable Contacts – Tracking Purposes
- ❑ Able to Provide Home/Residential/Shelter Address & Telephone Number

Exclusion:

- ❑ Unable to Complete Baseline Assessment
- ❑ Unable or Unwilling to Provide Informed Consent
- ❑ Admitted to VA Hospital for Psychiatric Reasons

SAFE-VET Initial Results

Acceptability of the SAFE VET Intervention to Veterans and Follow-up Mental Health Related Services Use

- Total number of Veterans referred to the SAFE VET Demonstration Project

  471
- Number of Veterans who agreed to receive the SAFE VET intervention

  438 (93%)
- Mean number of days between index ED visit and first follow-up
- *Mean = 4.4 (S.D. = 5.5)*
- Mean number of follow-up calls made by the Acute Services Coordinators
- *Mean = 6.2 (S.D = 4.4)*
- Percentage of SAFE VET Veterans who received **any psychiatric service** within 14 days of ED discharge (includes outpatient mental health, substance abuse services, or admission to the ED & other) =*(69%)*

SAFE-VET : Safety Plan & Follow-up Acceptance of Intervention (N=100)

- Overall effectiveness of SAFE-VET for staying safe:
  - **55% very helpful, 38% fairly helpful, 7% neutral**
- Satisfaction with Safety Planning Intervention:
  - **69% very satisfied, 28% satisfied, 3% neutral**
- 61% had used the Safety Plan to avert a suicidal crisis
- Funded by a grant from VA Mental Health Quality Enhancement Research Initiative (QUERI)

SAFE-VET : Safety Plan & Follow-up Acceptance of Intervention (N=100)

- Satisfaction with follow-up monitoring:
  - **76% very satisfied, 20% satisfied, and 4% neutral**
- Mean number of follow-up phone calls: 7.2 (SD = 3.92)
- Most helpful aspect of the phone calls:
  - **75% regularly checking in, 58% feeling cared for**

Quotes from Veterans

- “It helped a lot, because it's not like I came here and got pushed aside. I see that they really must be concerned because [the ASC] still calls me.”
- “It helped me not to be such a tough guy and actually go for the help that I needed.”
- “I think the program (safety plan and calls) saved my life actually.”
- “I wasn't actually paying attention much in the past, but [my clinician] pointed in the right direction. I probably wouldn't be here right now, to tell you the truth.”
- “I would tell others that it saved my life.”

Contacts and Resources

- Jan Kemp, PhD, Office of Mental Health Services, National Mental Health Program Director for Suicide Prevention and Community Engagement
- Stanley, B. & Brown, G.K. Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. Cognitive and Behavioral Practice, 19, 2, May 2012, 256-264.
- Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version
- Safety Planning Template: www.suicidesafetyplan.com

Population Based Approaches

- Means Restriction in the United Kingdom (Paractomol, Hawton et al Plos Med; 2012)
- Restricting firearm use (limited evidence)
- United States Air Force (USAF): Changing cultural norms following implementation of a population based, comprehensive suicide prevention program (Knox et al BMJ 2003, AJPH 2010, AJPH 2012)
- Sources of Strength (Wyman et al AJPH 2010)

Background

Evidence for Population Based Approaches

Means Restriction in the United Kingdom

- Coal burning
- Paractomol

Background

Evidence for Population Based Approaches

Firearms

- Limited evidence
- Social and political sensitivities

Population Based Approaches

USAF: Changing Cultural Norms

- USAF: Longitudinal epidemiologic studies of risk and protective factors
- USAF: Longitudinal studies of effectiveness of the implementation of a population based, comprehensive suicide prevention program

Research on Suicide Prevention in the Air Force

- Earliest and currently still only program to show a reduction in suicide rates over time (with exceptions)
- Leadership commitment in 2000 in engaging with an objective scientific partner (University of Rochester Medical Center) to investigate whether reduction in rates starting in 1996 was due to Air Force Suicide Prevention Program (AFSPP) or if there were alternative explanations for the drop in rates
- Continued research over the past decade has allowed for increasingly sophisticated methodology to examine the effectiveness of the program

The 11 Initiatives of the US Air Force Suicide Prevention Program

1. Leadership involvement: Air force leaders actively support the entire spectrum of suicide prevention initiatives in the air force community. Regular messages from the chief of staff of the air force, other senior leaders, and base commanders motivate the air force community to fully engage in suicide prevention efforts.

2. Addressing suicide prevention through professional military education: Suicide prevention education is included in all formal military training.

3. Guidelines for commanders on use of mental health services: Commanders receive training on how and when to use mental health services, and their role in encouraging early help seeking behavior.

The 11 Initiatives of the US Air Force Suicide Prevention Program (cont'd)

4. Community preventive services: Community prevention efforts carry more impact than treating individual patients 1 at a time. The Medical Expense and Performance Reporting System was updated to effectively track and encourage prevention activities.

5. Community education and training: Annual suicide prevention training is provided for all military and civilian employees in the air force.

6. Investigative interview policy: The period following an arrest or investigative interview is a high-risk time for suicide. Following any investigative interview, the investigator is required to ‘‘hand off’’ the individual directly to the commander, first sergeant, or supervisor. The unit representative is then responsible for assessing the individual's
emotional state and contacting a mental health provider if any question about the possibility of suicide exists.

The 11 Initiatives of the US Air Force Suicide Prevention Program (cont'd)

7. Trauma stress response (originally critical incident stress management): Trauma stress response teams were established worldwide to respond to traumatic incidents such as terrorist attacks, serious accidents, or suicide. These teams help personnel deal with the emotions they experience in reaction to traumatic incidents.

8. Integrated Delivery System (IDS) and Community Action Information Board (CAIB): At the air force, major command, and base levels, the CAIB and IDS provide a forum for the cross-organizational review and resolution of individual, family, installation, and community issues that impact the readiness of the force and the quality of life for air force members and their families. The IDS and CAIB help coordinate the activities of the various base helping agencies to achieve a synergistic impact on community problems and reduce suicide risk.

The 11 Initiatives of the US Air Force Suicide Prevention Program (cont'd)

9. Limited Privilege Suicide Prevention Program: Patients at risk for suicide are afforded increased confidentiality when seen by mental health providers (Limited Privilege Suicide Prevention Program). Additionally, Limited Patient-Psychotherapist Privilege was established in 1999, limiting the release of patient information to legal authorities during Uniform Code of Military Justice proceedings.

10. IDS Consultation Assessment Tool (originally the Behavioral Health Survey): The IDS Consultation Assessment Tool allows commanders to assess unit strengths and identify areas of vulnerability. Commanders can use this tool in collaboration with IDS consultants to design interventions to support the health and welfare of their personnel.

11. Suicide Event Surveillance System: Information on all air force active duty suicides and suicide attempts are entered into a central database that tracks suicide events and facilitates the analysis of potential risk factors for suicide in air force personnel.

Initial Findings

- Knox KL, Litts DA, Talcott GW, Feig JC, Caine ED. "Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the United States Air Force." Cohort study. British Medical Journal; 2003; 327: 1376.
  - Rejected other explanations for drop in suicide rates following implementation of the program in 1995-1996
  - Concluded that the drop in suicide rates, as well as other violence related outcomes, *suggested* that the program was responsible for the drop in rates

Limitations of 2003 Studies

- No data to demonstrate whether similar drops had occurred historically
- No data on implementation of the program to suggest an underlying mechanism
- No data on downsizing of the force during the time and suicide rates

Addressing the Limitations

- Initial collection of implementation data in 2004
- Collection of implementation data again in 2006
- Presence of a natural experiment when rates spiked upward in 2004
- Use of a forecasting model using suicide data from 1981-2008

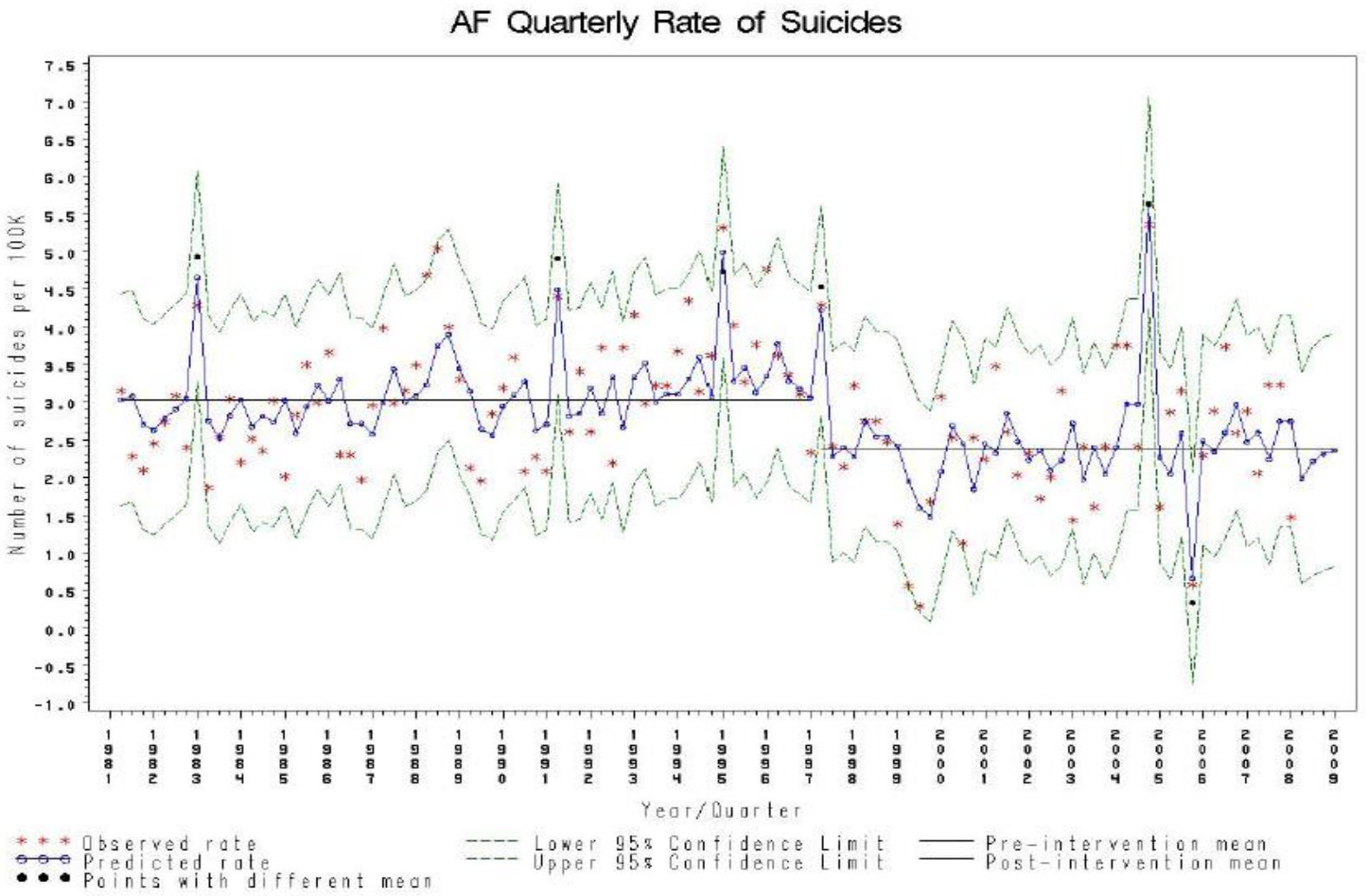
Objectives, Methods and Results

- Objectives
  - Evaluate the effectiveness of the AFSPP and develop population-based indicators of potential shifts in patterns of suicide rates.
- Methods
  - The impact of the AFSPP on suicide rates was determined by applying an intervention regression model to 1981-2008 data. Implementation of program components was measured before and after an increase in suicide rates during 2004.
- Results
  - Suicide rates in the Air Force were significantly lower in the twelve years following initiation of the AFSPP, except during a period when program implementation appeared to diminish.

Results

- Suicide rates in the Air Force were significantly lower in the twelve years following initiation of the AFSPP, except during a period when program implementation appeared to diminish.
- To provide AF leadership with tools for early detection of potential future increase in suicide rates, risk indicators were developed based on the forecasted suicide rate for 2008 of 9.3/100,000.
- Rates within one standard deviation from the forecast rate (<12.1/100,000) were identified as indicators of concern. Rates greater than one standard deviation from the forecast rate (12.1-14.8/100,000) were defined as indicators of warning and rates greater than two standard deviations from the forecast rate (>14.8/100,000) were identified as critical indicators of a change in the pattern of suicide rates in the USAF.

Graphics


AF Quarterly Rate of Suicides
Number of suicides per 100K
7.5
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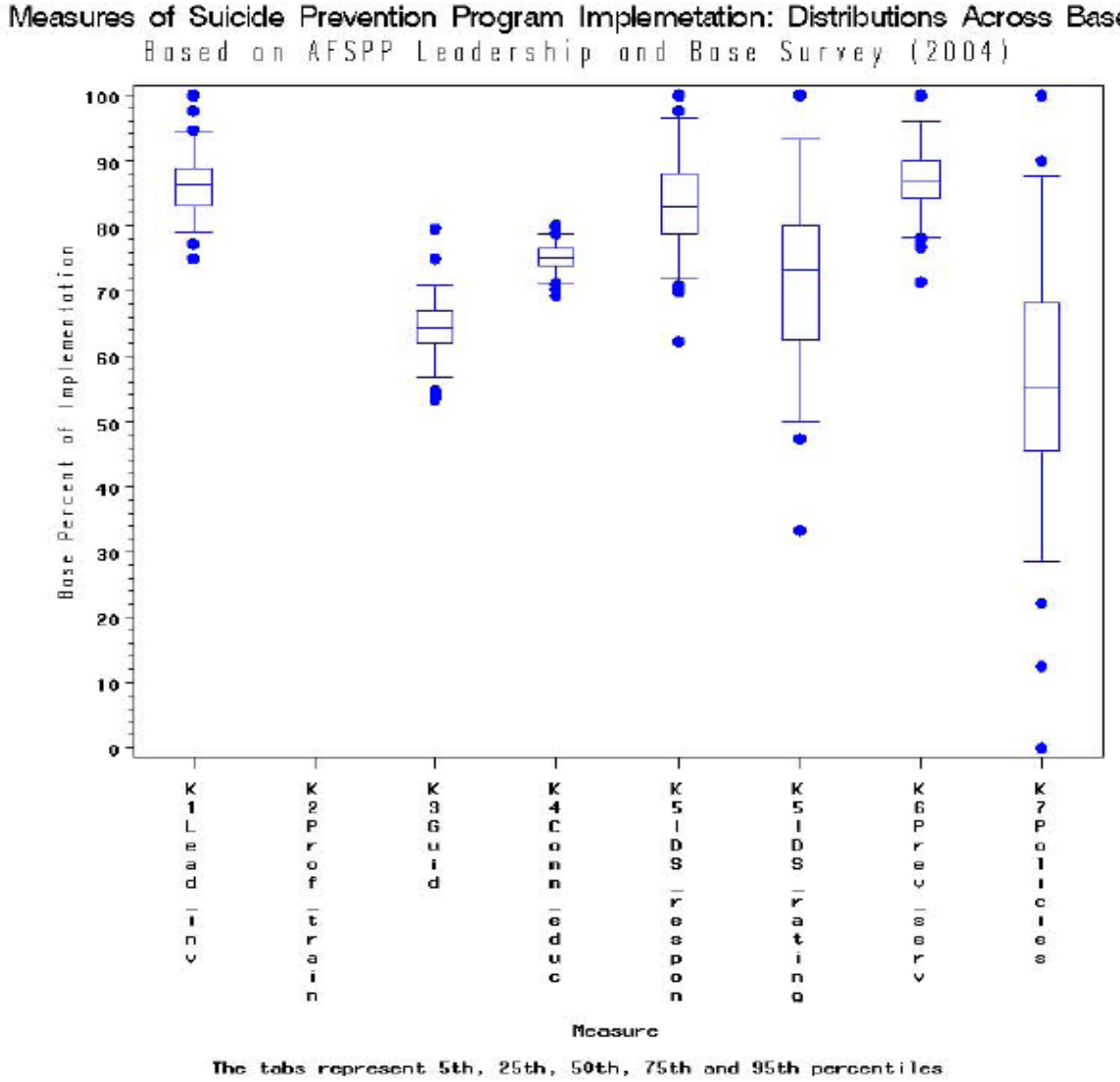
Year/Quarter
Observed rate
Predicted rate
Points with different mean
Lower 95% Confidence Limit
Upper 95% Confidence Limit
Pre-intervention mean
Post-intervention mean

Graphics


Measures of Suicide Prevention Program Implemetation: Distributions Across Bases
Based on AFSPP Leadership and Base Survey (2004)
Base Percent of Implementation
100
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K1Lead_inv
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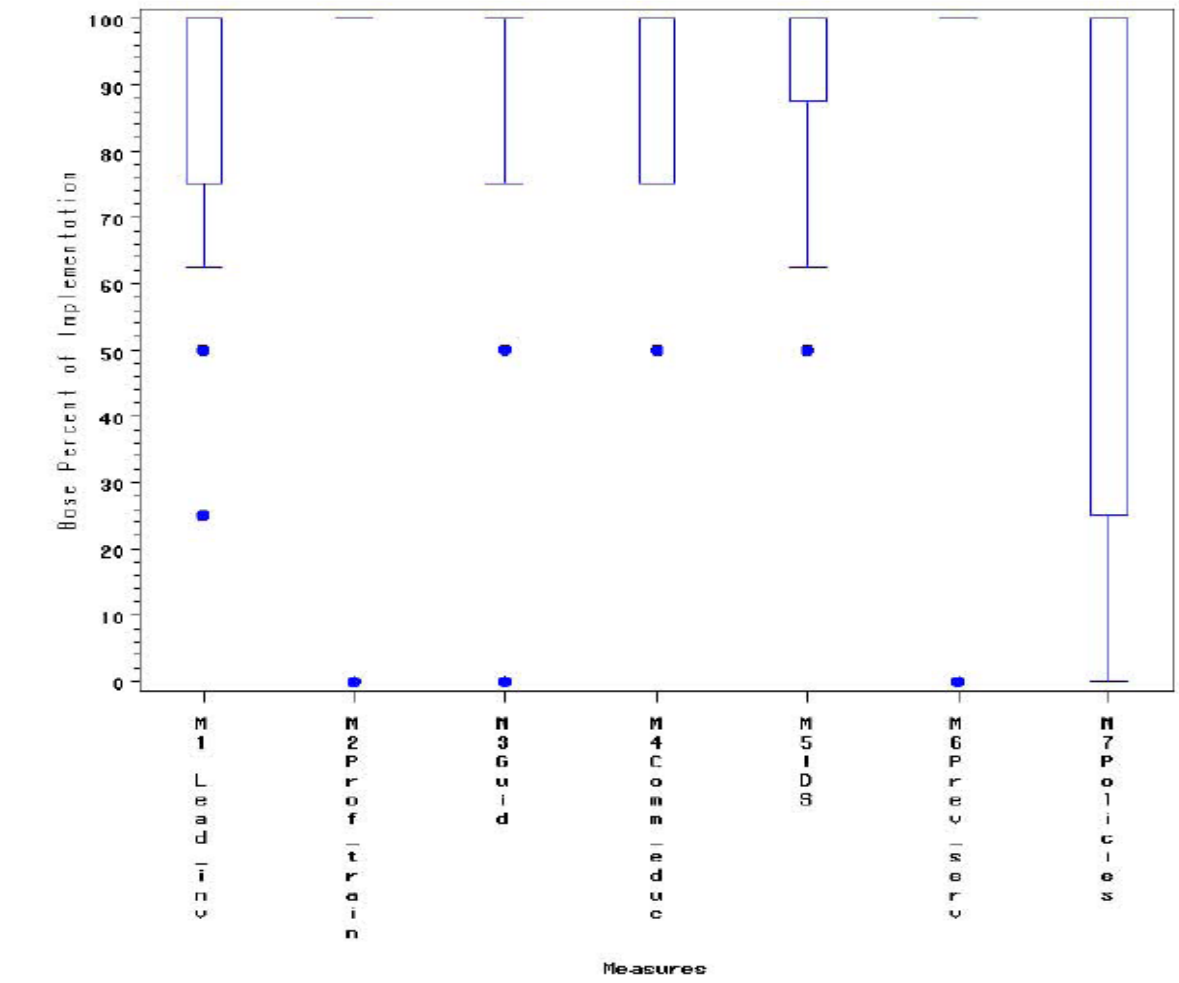
K3Guid
K4Comm_educ
K5IDS_respon
K5IDS_rating
K6Prev_serv
K7Policies
Measure
The tabs represent 5th, 25th, 50th, 75th and 95th percentiles

Graphics


Measures of Suicide Prevention Program Implemetation: Distributions Across Bases
Based on AFSPP check list (2006)
Base Percent of Implementation
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M2 Prof_train
M3 Guid
M4 Comm_educ
M5 IDS
M6 Prev_serv
M7 Policies
Measures
The tabs represent 5th, 25th, 50th, 75th and 95th percentiles

Conclusion

- The AFSPP is one model of suicide prevention with sustainable results, with evidence now that this sustainability requires constant application of a high degree of program implementation and monitoring.

- The public health policy message, that deaths from suicide can be reduced through a multi-layered, overlapping approach encompassing key prevention domains and monitoring compliance, is a critical communication for policy makers and clinicians in the U.S. and worldwide.

Conclusion

- This approach may be promising for reducing morbidity and mortality due to suicide in diverse communities and organizations, replacing piecemeal approaches that either fail to demonstrate effectiveness or are unsustainable.

Knox KL, Pflanz S, Talcott GW, Campise RL, Lavigne JE, Bajorska A, Tu X, Caine ED. The Air Force Suicide Prevention Program: Implications for public health policy. American Journal of Public Health; [Epub ahead of print: May 13, 2010, 10.2105]

Purpose of these Studies

- To longitudinally study the effectiveness of the AFSPP
- To potentially contribute to the sustainability of the program over time
- To potentially contribute to understanding which components of the program are most effective
- To investigate the relationship of compliance with program and suicide rates
- To develop population-based indicators of potential shifts in patterns of suicide rates

Current Studies in Progress

- Examination of relationship of implementation and suicide rates at the MAJCOM (Major Command) and base installation level
  - Implementation data for 2006, 2007, 2008, 2009, 2010, and 2011 currently being cleaned and merged
  - Analyses are planned at MAJCOM level
  - Questions regarding future measurement of the program, possible programmatic changes

Other Studies

- Psychopathology of suicide (Conner KR et al; SLTB; 2012)
- Models for suicides with the mental disorders episodes as predictors
- To account for varying time of exposure and censoring we performed Cox proportional hazard survival model with 3 broad predictors: ‘any mood’ (depression or bipolar), ‘any anxiety’ (anxiety or PTSD), and ‘any substance’ (alcohol or drugs)

Current Studies in Progress

- Having an episode of any mood (depression or bipolar), any anxiety (anxiety or PTSD) or any substance (alcohol or other substance), as detected in health care system, increases chances of suicide

- The hazard of suicide is almost 9 times higher; 90% CI is [6.21, 12.32] for an individual in the first year following the beginning of mood episode compared to individual who is not in ongoing episode. Similar hazard ratio for anxiety is 4.2; 90% CI is [2.17, 8.32]

Publications

- Conner KR, McCarthy M, Bajorska A, Caine ED, Tu X, Knox KL. Mood, Anxiety, and Substance Use Disorders and Suicide Risk in a Military Population Cohort; Suicide Life Threat Behav. 2012 Oct 24. doi:10.1111/j.1943-278X.2012.00125.x. [Epub ahead of print]

Collaborators

Air Force

- Col David Litts
- Col G. Wayne Talcott
- Maj Jill Feig
- Col Rick Campise
- Col Stephen Pflanz
- Lt Col Michael Kindt
- Maj Michael McCarthy
- Maj Kathleen Crimmins
- Lt Col Wendy Travis

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IMS Government Solutions:

- Don DeGroff, Project Manager
- Timothy Champney, Ph.D.
- Sewit Araia, MPH

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- University of Rochester Department of Psychiatry funding, (Knox KL, PI) 07/01/2000-09/30/2001
  - Feasibility study of working with AF partners to study the AFSPP
- DOD/Army/ AMRDC (DAMD17-01-1-0797), (Knox KL, PI) 09/01/2001-08/31/2002
  - Evaluation of the Adaptation of a WHO/CDC Public Health Model of Suicide Prevention Implemented in the USAF
- NIMH K01 MH6631 (Knox KL, PI) 7/22/2002-07/31/2007
  - Prospective Study of Suicide Prevention in the USAF
- NIMH R01 MH07501 (Knox KL, PI) 7-01A1 08/24/2006-05/30/11
  - Components of Effective Suicide Prevention in the USAF
  - No cost extension starting 06/01/11-05/30/12

Acknowledgements

- NIMH P20 MH071897(Caine ED, PI, Knox KL, Co-PI) 07/01/2004 – 06/30/2009 The Developing Center on Public Health and Population Interventions for the Prevention of Suicide (PHP-Center)

- 2R01MH075017-06A1 (PI Knox KL) Individual and Community and Organizational Factors for Suicide Risk in the USAF

Funding

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Example 2: Changing Cultural Norms

Wyman et al (2010); 2010, American Journal of Public Health

Peer Leaders Increased:

- Attitudes towards self disclosure, positive coping, school engagement (ES= 0.22—0.75)
- Connections to adults (ES = 0.49)
- Largest gains for least connected peer leaders

School Population Increased:

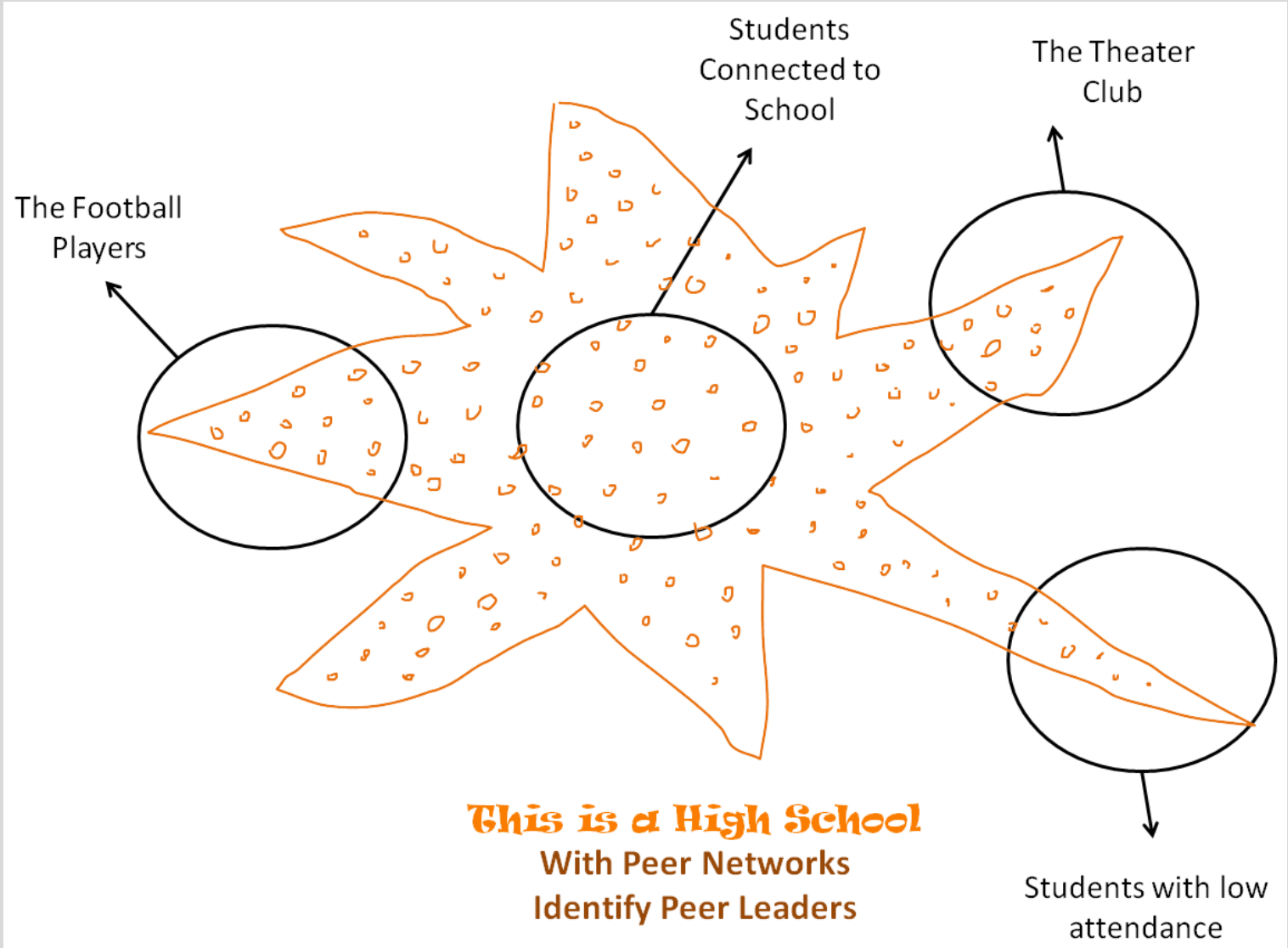
- Help-seeking acceptability (ES=0.58)
- Perception that adults help suicidal peers (ES= 0.63)
  - Largest gains for suicidal students

Overview

- Description of Sources of Strength
  - Delivered by diverse adolescent peer
  - Promote healthy culture and norms – through messaging in social networks
  - Research-based: secondary school populations

- Proposed Wingman-Strong
  - Adapt Sources of Strength for the USAF wingman culture
  - Partnership of U Rochester and USAF
  - Iterative process with topic expert input

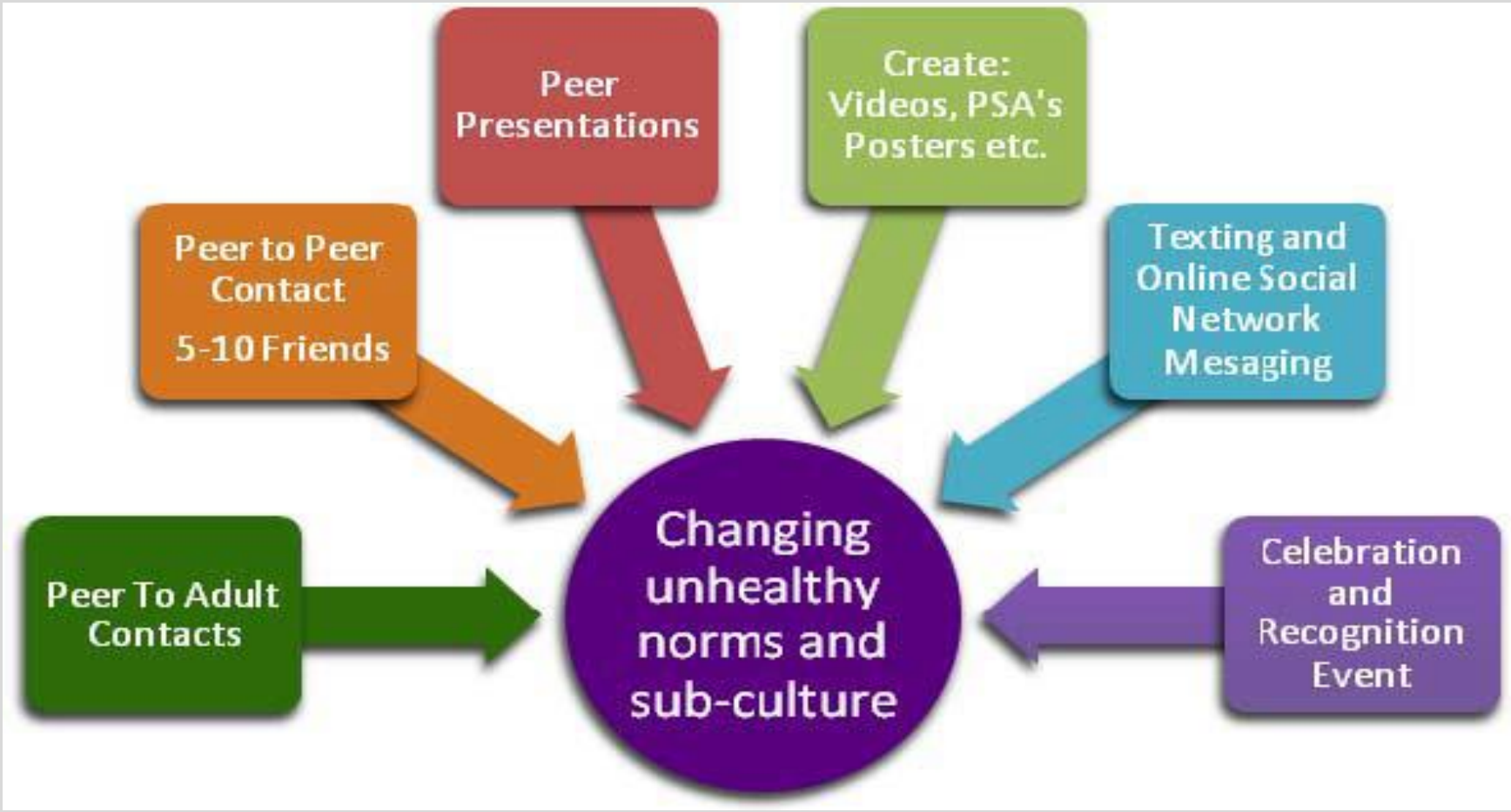
Selection of Diverse Student Leaders



Sources of Strength

The more you have, the better you can handle life's ups and downs .

Peer Leader Messaging Format



Peer Leaders Conduct Messaging Projects with Adult Mentoring

All students at Perry High School named their Trusted Adults and formed a growing circle of trust

1st Evaluation of Sources of Strength Using Randomized Wait-Listed Design

- 18 high schools (Georgia, New York, North Dakota)
  - 465 Peer Leaders
  - 2,700 students in population
- Randomized to: Immediate or Wait-listed for 5 months
- Acceptable to communities/schools and possible to draw strong conclusions and program impact
- Tested effects on changing population norms/practices
  - Help-seeking, coping norms
  - Not large enough to test impact on suicidal behavior

Funded by SAMHSA, NIMH, NY State

Impact of Intervention

Peer Leaders Increased:

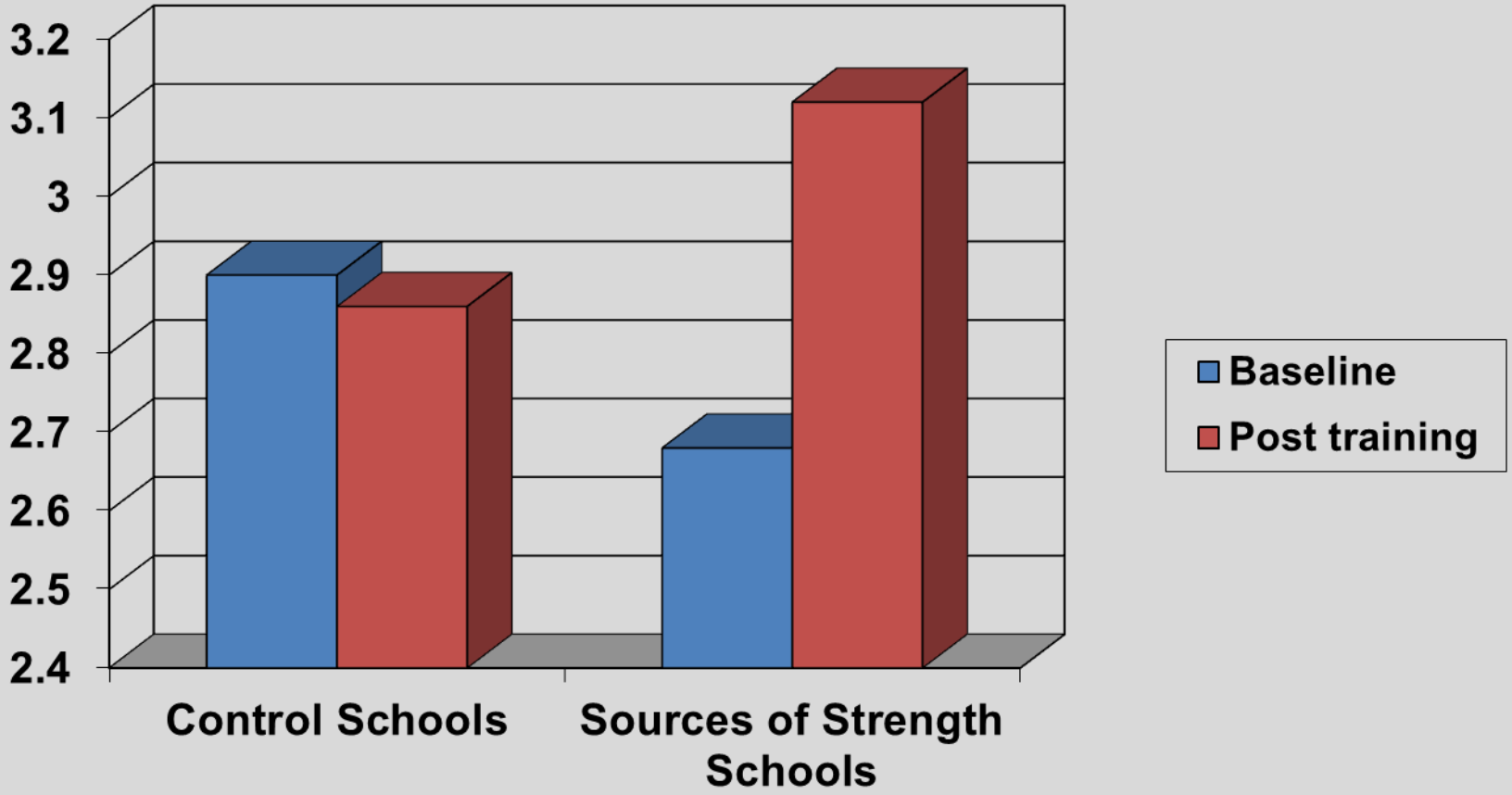
- Attitudes towards self disclosure, positive coping, school engagement (ES = 0.22 – 0.75)
- Connections to adults (ES=0.49)
- Peer Leaders 4X more likely to refer peers to adults
- Largest gains for least connected peer leaders

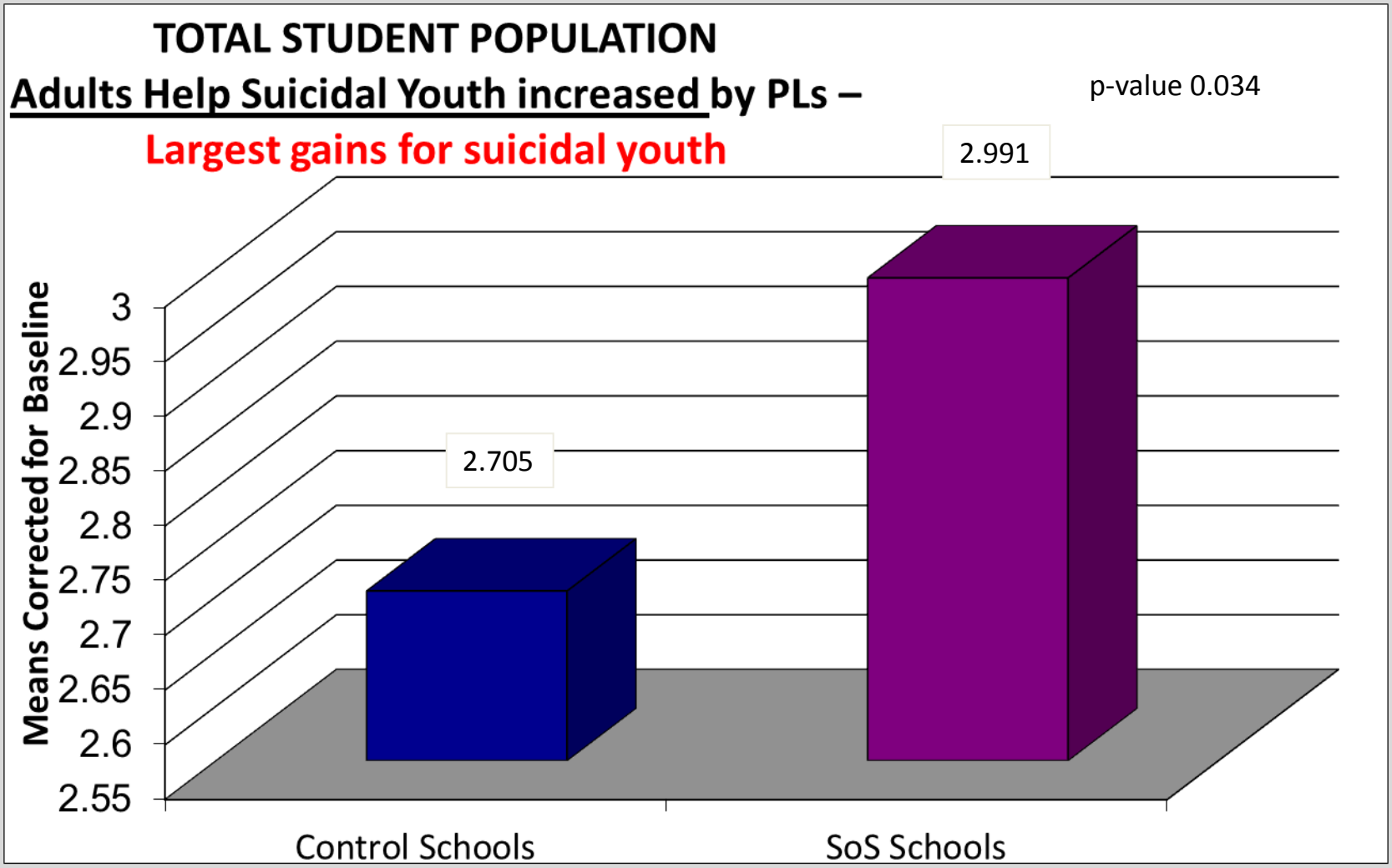
School Population Increased:

- Help-Seeking acceptability (ES=0.58)
- Perception that adults help suicidal peers(ES=0.63)
  - Largest gains for suicidal students

Wyman et al., 2010, American Journal of Public Health

Help-Seeking Norms of Peer Leaders increased (p<.05)




TOTAL STUDENT POPULATION
Adults Help Suicidal Youth increased by PLs –
Largest gains for suicidal youth
p-value 0.034
2.991
2.705
Means Corrected for Baseline
3
2.95
2.9
2.85
2.8
2.75
2.7
2.65
2.6
2.55
Control Schools
SoS Schools

Summary

- Clinical Approaches
  - Evidence for individual psychotherapeutic interventions, including brief behavioral interventions, as well as well as medications
  - Suicide rate has not decreased in the nation

VA/DoD Practice Guidelines for Suicide Prevention (Summary from Recent Report)

RECOMMENDATIONS

1. Dialectical Behavioral Therapy (DBT) for patients with Borderline Personality Disorder (BPD) [C] or other personality disorders
2. Psychotherapies based on cognitive or behavioral approaches or skills training (i.e., CBT for Borderline Personality Disorder, MACT, Acceptance Based Emotion Regulation Group Intervention) for patients with borderline personality disorder (BPD) who are at high risk for suicide
3. Specific psychodynamic psychotherapies (i.e., MBT, brief psychodynamic interpersonal therapy) for patients with borderline personality disorder (BPD) who are a high risk for suicide

Va/DoD Clinical Practice Guideline for Suicide Prevention (2013)

VA/DoD Practice Guidelines for Suicide Prevention (Summary from Recent Report)

RECOMMENDATIONS

- High risk patients for suicide should be monitored for at least one year.

- Patients identified as intermediate risk for suicide (never engaged in suicidal behaviors) should be followed for at least 6 months after suicidal ideation is resolved.

- Patients who have been identified as low risk may be followed by their primary care provider and periodically re-assessed for suicidal risk.

Va/DoD Clinical Practice Guideline for Suicide Prevention (2013)

Summary

- Population Approaches
  - No mandate for reporting suicide attempts
  - Effectiveness of community/population level interventions difficult to study
  - Integration of clinical mental health community and public health community remains difficult
  - Population rates have not decreased in the US

Way Forward

- National Action Alliance for Suicide Prevention
- Coordination of national efforts to advance the field
  - Multiple task forces
  - Resources

Thank you, questions?

- Submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.
- The question box is monitored and questions will be forwarded to our presenter for response.
- We will respond to as many questions as time permits.

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